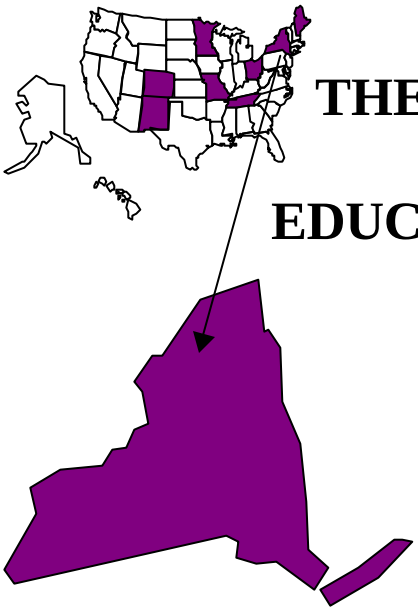

THE HEALTH CARE WORKFORCE IN EIGHT STATES: EDUCATION, PRACTICE AND POLICY

Spring 2002

NEW YORK

TABLE OF CONTENTS

The Health Care Workforce in Eight States: Education, Practice and Policy

PROJECT DESCRIPTION

Historically, both federal and state governments have had a role in developing policy to shape the health care workforce. The need for government involvement in this area persists as the private market typically fails to distribute the health workforce to medically underserved and uninsured areas, provide adequate information and analysis on the nature of the workforce, improve the racial and ethnic cultural diversity and cultural competence of the workforce, promote adequate dental health of children, and assess the quality of education and practice.

It is widely agreed that the greatest opportunities for influencing the various environments affecting the health workforce lie within state governments. States are the key actors in shaping these environments, as they are responsible for:

- financing and governing health professions education;
- licensing and regulating health professions practice and private health insurance;
- purchasing services and paying providers under the Medicaid program; and
- designing a variety of subsidy and regulatory programs providing incentives for health professionals to choose certain specialties and practice locations.

Key decision-makers in workforce policy within states and the federal government are eager to learn from each other. This initiative to compile in-depth assessments of the health workforce in 8 states is an important means of insuring that states and the federal government are able to effectively share information on various state workforce data, issues, influences and policies.

Products of this study include individual health workforce assessments for each of the eight states and a single assessment that compares various data and influences across the eight states. In general, each state assessment provides the following:

1) A summary of health workforce data, available resources and a description of the extent the state invests in collecting workforce data. [Part of this information has been provided by the Bureau of Health Professions];
2) A description of various issues and influences affecting the health workforce, including the state's legislative and regulatory history and its current programs, financing and policies affecting health professions education, service placement and reimbursement, planning and monitoring, and licensure/regulation;
3) An assessment of the state's internal capacity and existing strategies for addressing the above workforce issues and influences; and
4) An analysis of the policy implications of the state's current workforce data, issues, capacity and strategies.

The development of the project's data assimilation strategy, content and structure was guided by an expert advisory panel. Members of the advisory panel included both experts in state workforce policy (i.e., workforce planners, researchers and educators) and, more broadly, influential state health policymakers (i.e., state legislative staff, health department officials). The advisory panel has helped to ensure the workforce assessments have an appropriate content and effective format for dissemination and use by both state policymakers and workforce experts/officials.

STUDY METHODOLOGY

Study Purpose and Audience

Key decision-makers in workforce policy within states and the federal government are eager to learn from each other. Because states increasingly are being looked to by the federal government and others as proving grounds for successful health care reform initiatives, new and dynamic mechanisms for sharing innovative and effective state workforce strategies between states and with the federal government must be implemented in a more frequent and far reaching manner. This initiative to compile comprehensive capacity assessments of the health workforce in 8 states is an important means of insuring that states and the federal government are able to effectively share information on various state workforce data, issues and influences.

Each state workforce assessment report is not intended to be voluminous; rather, information is presented in a concise, easy-to-read format that is clearly applicable and easily digestible by busy state policymakers as well as by workforce planners, researchers, educators and regulators.

Selection of States

NCSL, with input from HRSA staff, developed a methodology for identifying and selecting 8 states to assess their health workforce capacity. The methodology included, but was not limited to, using the following criteria:

a. States with limited as well as substantial involvement in one or more of the following areas: statewide health workforce planning, monitoring, policymaking and research;
b. States with presence of unique or especially challenging health workforce concerns or issues requiring policy attention;
c. States with little involvement in assessing health workforce capacity despite the presence of unique or especially challenging health workforce concerns or issues requiring policy attention;
d. Distribution of states across Department of Health and Human Services regions;
e. States with Bureau of Health Professions (BHPr) - supported centers for health workforce research and distribution studies;
f. States with primarily urban and primarily rural health workforce requirements; and
g. States in attendance at BHPr workforce planning workshops or states that generally have interest in workforce modeling.

Collection of Data

NCSL used various means of collecting information for this study. Methods exercised included:

a. Phone and mail interviews with state higher education, professions regulation, and recruitment/retention program officials;
b. Custom data tabulations by national professional trade associations and others (i.e., Quality Resource Systems, Inc.; Johns Hopkins University School of Public Health) with access to national data bases;
c. Tabulations of data from the most recent edition of federal and state government databases (e.g., National Health Service Corps field strength);
d. Site visit interviews with various officials in the ten profile states;
e. Personal phone conversations with other various state and federal government officials;
f. Most recently available secondary data sources from printed and online reports, journal articles, etc.; and
g. Comments and guidance from members of the study's expert advisory panel.

STATE SUMMARY

Although New York is largely metropolitan, the upper portion of the state has a significant rural population. The state's minority and ethnic population accounts for over a third of New York's total population. By various indicators, New York residents enjoy higher access to health care services than most states.

New York state government has a long history of addressing state health workforce issues in the context of larger health system changes and reforms. Until recently, most public third party payment rates to the state's hospital and health care system historically have been centrally regulated by the state. The state has numerous grant and loan programs intended to improve the supply of health professionals in primary care and long-term care disciplines and in rural and indigent underserved communities. State officials rank their initiatives to recruit medical students from rural or underserved areas and state support for health professions education in underserved communities as having a major impact on recruiting and retaining health professionals to needy areas of the state. In addition, New York devotes significant attention to better understanding its health workforce needs through collection and analysis of data on the state's health professions in training and practice. The Center for Health Workforce Studies at the State University of New York in Albany routinely provides state officials and others respected reports and analyses of physician and nurse supply in the state. The state hospital and nursing associations, as well as the state's major health professional licensing boards, also regularly collect workforce data on members or licensees that is made available to state policymakers.

A recent economic recession and growing shortages of nurses and other health professionals in the state have focused attention on the need to establish a major new state-funded health workforce retraining initiative. The latest initiative is supported by a coalition of hospitals, nursing homes, nurse executives, home care agencies and adult care facilities. Health care workers in these settings are heavily unionized in New York, and such unions have significant influence on state policymakers. In early 2002, a $3 billion health care plan proposed as part the new fiscal year budget by New York's governor (who is seeking re-election in 2002)—approved by the Legislature and endorsed by the state's powerful hospital union—increases salaries for health care employees and restores some reductions in Medicaid services that were previously proposed. The plan also provides $80 million in grants to hospitals, nursing homes and other qualified agencies for recruitment, retention and training of health care workers, and awards $28 million for various primary care initiatives and projects.

New York has the second highest proportion of practicing physicians per 100,000 population of any state in the country. However, despite such overall abundance of physicians statewide, there are many areas of the state—particularly rural in nature—where supply of specialty and primary care physicians is low and access to care is limited. New York is a major producer of physicians and fares well at retaining them.

With over 300,000 licensed nurses, New York has the second largest population of nurses in the nation. Despite this abundance of nurses, there are indications in New York of a growing nursing shortage. Recent surveys find that three-quarters of the state's hospitals report nursing shortages, particularly outside of New York City. The state has been slow to provide support to address the shortage problem. Legislation in 2001 calling for a limitation on mandatory overtime for nurses, creation of a minimum nurse staffing formula, whistleblower protection, creation of a statewide nurse staffing center, and establishment of a state nursing scholarship program await lawmaker action in 2002.

New York has focused much less attention on the dental and pharmacy workforce. As elsewhere, the shortage of dentists who serve Medicaid recipients is a problem in New York. Concerns by dentists over low Medicaid payment rates resulted in a 2000 suit of the state by the state dental association. As a result of the suit, dentists won the right to receive incremental Medicaid rate increases.

I. WORKFORCE SUPPLY AND DEMAND

Arguably, it is most important initially to understand the marketplace for a state's health care workforce. How many health professionals are in practice statewide and in medically underserved communities? What are the demographics of the population served? How is health care organized and paid for in the state? This section attempts to answer some of these questions by presenting state-level data collected from various sources.

Table I-a.

POPULATION		NY	U.S.
Total Population (2000)		**18,976,457**	281,421,906
Sex (2000)	% Female	**51.8**	50.9
	% Male	**48.2**	49.1
Age (2000)	% less than 18	**24.7**	25.7
	% 18-64	**62.4**	61.9
	% 65 or over	**12.9**	12.4
% Minority/Ethnic (1997-1999)		**35.6**	29.1
% Metropolitan (2000)*		**92.1**	79.9

* As defined by the U.S. Office of Management and Budget

Sources: U.S. Census Bureau, AARP.

Over 90% of New York residents live in metropolitan areas.

Table I-b.

PROFESSION UTILIZATION	NY	U.S.
% Adults who Reported Having Routine Physical Exam Within Past Two Years (1997)	**87.1**	83.2 (Median)
Average # of Retail Prescription Drugs per Resident (1999)	**9.9**	9.8
% Adults who Made Dental Visit in Preceding Year by Annual Family Income (1999):		
Less than $15,000	**53**	
$15,000 - $34,999	**64**	
$ 35,000 or more	**79**	

Sources: CDC, AARP, GAO.

Eight-seven percent of New York adults report having a routine physical exam within the past two years.

Table I-c.

ACCESS TO CARE		NY	U.S.
% Non-elderly (under age 65) Without Health Insurance	1999-2000	**17**	16.0
	1997-1999	**19**	18.0
% Children Without Health Insurance	1999-2000	**11**	12.0
	1997-1999	**14**	14.0
% Not Obtaining Health Care Due to Cost (2000)		**8.8**	9.9
% Living in Primary Care HPSA (2001)		**19.1**	19.9
# Practitioners Needed to Remove Primary Care HPSA Designation (2001)		**273**	--
% Living in Dental HPSA (2001)*		**10.2**	13.7
# Practitioners Needed to Remove Dental HPSA Designation (2001)		**222**	--

HPSA = Health Professional Shortage Area
* It is commonly believed that there are additional areas in the state that may be eligible to receive HPSA designation.

Sources: KFF, AARP, BPHC-DSD.

Less than 9% of New York residents report not obtaining health care due to cost.

Table I-d.

PROFESSIONS SUPPLY				
Profession		**# Active Practitioners**	**# Active Practitioners per 100,000 Population**	
			NY	**U.S.**
Physicians (1998)		**48,113**	**265**	198
Physician Assistants (1999)		**3,427**	**18.8**	10.4
Nurses	RNs (2000)	**160,009**	**843**	782
	LPNs (1998)	**48,760**	**268.5**	249.3
	CNMs (2000)	**568**	**3.1**	2.1
	NPs (1998)	**7,356**	**40.5**	26.3
	CRNAs (1997)	**733**	**4.0**	8.6
Pharmacists (1998)		**12,640**	**69.6**	65.9
Dentists (1998)		**11,497**	**63.3**	48.4
Dental Hygienists (1998)		**14,710**	**81.0**	52.1
% Physicians Practicing Primary Care			**35.0** (30.0 U.S.)	
% Registered Nurses Employed in Nursing			**81.0** (81.7 U.S.)	
% of MDs Who Are International Medical Graduates (IMGs)			**43.0** (24.0 U.S.)	

RN= Registered Nurse, LPN= Licensed Practical Nurse, CNM= Certified Nurse Midwife, NP= Nurse Practitioner
CRNA= Certified Registered Nurse Anesthetist

Source: HRSA-BHPr.

New York has more physicians, physician assistants, nurses, pharmacists, dentists and dental hygienists per 100,000 population than the U.S. as a whole.

Table I-e.

NATIONAL HEALTH SERVICE CORPS (NHSC) FIELD STRENGTH			
Total Field Strength (FY 2001) * Includes mental/behavioral health officials	% in Urban Areas	% in Rural Areas	# Per 10,000 Population Living in HPSAs
139	**79**	**21**	**0.38** (0.49 U.S.)

Field Strength by Profession	
Physicians	**85**
Nurses	**12**
Physician Assistants	**20**
Dentists/Hygienists	**11**

HPSA= Health Professional Shortage Area

Source: BHPr-NHSC.

New York's National Health Service Corps field strength per 10,000 HPSA population is lower than the national average.

Table I-f.

MANAGED CARE				
Penetration Rate of Commercial and Medicaid HMOs (as % of total population), 2000			**NY**	**U.S.**
			34.0	28.1
Profession	MCOs required by state to include profession on their provider panel*	Profession allowed by state to serve as primary care provider in MCOs	Profession allowed by state to coordinate primary care as part of a standing referral	Profession allowed by state to engage in collective bargaining with MCOs
Physicians	**No**	**No**	**No**	**No**
Nurses	**No**	**No**	**No**	**No**
Pharmacies	**No**	**No**	**No**	**No**
Dentists	**No**	**No**	**No**	**No**
State requires certain individuals enrolled in MCOs to have direct access to certain specialty (OB/GYN, etc.) providers.				**Yes**
State requires certain individuals enrolled in MCOs to receive a standing referral to a specialist (OB/ GYN, etc.).				**Yes**

MCOs = Managed Care Organizations HMOs = Health Maintenance Organizations OB/GYN = Obstetrician/Gynecologist

* This requirement does not preclude MCOs from including additional professions on their provider panels.

Sources: HPTS, AARP.

Thirty-four percent of New York residents receive health care from an HMO.

Table I-g.

REIMBURSEMENT OF SERVICES					
	Profession	% Active Practitioners Enrolled	% Enrolled Receiving Annual Payments Greater Than $10,000[1]	Increase of 10% or More in Overall Payment Rates 1995-2000	Bonus or Special Payment Rate for Practice in Rural or Medically Underserved Area
Medicaid	Physicians	*	**7.4**	**No**	**Yes**
	NPs	*	**0.1**	**No**	**No**
	Dentists	*	**10.4**	**No**	**No**
	# of Enrolled Pharmacies				**6,621**
	% Change in Physician Fees (All Services), 1993-1998				**(2.98)**
	Recent State-Mandated Payment Increases				**Yes (Dentists)**
Medicare	# Active Practitioners Enrolled (2000)				**40,365**
	% Practitioners who Accept Fee as Full Payment (2001)				**81.0**

[1] Generally seen as an indicator of significant participation in the Medicaid program.
[2] Denominator number from HRSA State Health Workforce Profile, December 2000.
* Numerator data for physicians and nurse practitioners from state Medicaid agencies were unusable: many professionals were apparently double-counted, perhaps due to varying participation in different health plans.

Sources: State Medicaid programs, Norton and Zuckerman "Trends", HPTS, AARP.

Medicaid physician fees actually decreased between 1993 and 1998.

II. HEALTH PROFESSIONS EDUCATION

State efforts to help ensure an adequate supply of health professionals can be understood in part by examining data on the state's health professions education programs–counts of recent students and graduates, amounts of state resources invested in education, and other factors. State officials can gauge how well these providers reflect the state's population by also examining how many students and graduates are state residents or minorities. Knowing to what extent states are also investing in primary care education and how many medical school graduates remain in-state to complete residencies in family medicine is also important.

Table II-a.

UNDERGRADUATE MEDICAL EDUCATION			
# of Medical Schools *(Allopathic and Osteopathic)*	**13**	Public Schools	**4**
		Private Schools	**9**
		Osteopathic Schools	**1**
# of Medical Students *(Allopathic and Osteopathic)*	1997-1998	**7,968**	
	1999-2000	**7,944**	
# Medical Students per 100,000 Population[1]	1999-2000	**41.9**	
% Newly Entering Students (*Allopathic)* who are State Residents, 1999-2000		**60.5**	
Requirement for Students in Some/All Medical Schools to Complete a *Primary Care Clerkship*	By the State	**No**	
	By Majority of Schools	**Yes**	
# of Medical School Graduates *(Allopathic and Osteopathic)*	1998	**1,970**	
	2000	**1,953**	
# Medical School Graduates per 100,000 Population[1]	2000	**10.3**	
% Graduates *(Allopathic)* who are Underrepresented Minorities, 1994-1998		**8.43** (10.5 U.S.)	
% 1987-1993 Medical School Graduates *(Allopathic)* Entering Generalist Specialties		**21.35** (26.7 U.S.)	
State Appropriations to Medical Schools *(Allopathic and Osteopathic)*, 1999-2000	Total	**$ 204 million**	
	Per Student	**$ 25,685**	

[1] Denominator number is state population from 2000 U.S. Census.

Sources: AAMC, AAMC Institutional Goals Ranking Report, AACOM, Barzansky et al. "Educational Programs", State higher education coordinating boards.

Just 60% of newly entering medical students in New York are state residents.

Table II-b.

GRADUATE MEDICAL EDUCATION (GME)		
# of Residency Programs *(Allopathic and Osteopathic)*, 1999-2000[1]		**1,129**
# of Physician Residents *(Allopathic and Osteopathic)*, 1999-2000[1]		**14,738**
# Residents Per 100,000 Population, 1999-2000		**77.7**
% Allopathic Residents from In-State Medical School, 1999-2000		**25.7**
% Residents who are International[2] Medical Graduates, 1999-2000		**48.9** (26.4 U.S.)
Requirement to Offer Some or All Residents a *Rural Rotation*	By the State	**No**
	By Most Primary Care Residencies	**No**
State Appropriations for Graduate Medical Education, 1996-1997[4,5]	Total	**Data not available**
	Per Resident	**Data not available**
Medicaid Payments for Graduate Medical Education, 1998[3]		**$ 812 million**
	Payments as % of Total Medicaid Hospital Expenditures	**15.0** (7.4 U.S.)
	Payments Made Directly to Teaching Programs Under Capitated Managed Care	Yes
	Payments Linked to State Workforce Goals/ Goals of Improved Accountability	**No**
Medicare Payments for Graduate Medical Education, 1998[3]		**$1.22 billion**

[1] Includes estimated number of osteopathic residencies/residents not accredited by the Accreditation Council for Graduate Medical Education.
[2] Does not include residents from Canada.
[3] Explicit payments for both direct and indirect GME cost.
[4] Funds largely are for graduate education.
[5]Dollar amounts refer largely to funding for family medicine training programs. However, these funds that flow directly to teaching hospitals are not necessarily earmarked by the state for graduate medical education.

Sources: AMA, AMA State-level Data, AACOM, State higher education coordinating boards, Henderson "Funding", Oliver et al. "State Variations."

Almost half of New York physician residents are international medical graduates—a proportion that is double the national average.

Table II-c.

FAMILY MEDICINE RESIDENCY TRAINING			
# of Residency Programs, 2001	**26**	# Residencies Located in Inner City	**10**
		# Residencies Offering Rural Fellowships or Training Tracks	**2**
# of Family Medicine Residents, 1999-2000			**92**
# Family Medicine Residents per 100,000 Population[1]			**0.48**
% Graduates *(from state's Allopathic and Osteopathic medical schools)* who were First Year Residents in Family Medicine, 1995-2000			**6.7** (14.8 U.S.)
% Graduates *(from state's Allopathic medical schools)* Choosing a Family Medicine Residency Program Who Entered an In-State Family Medicine Residency, 1995-2000			**34.4** (48.1 U.S.)
State Appropriations for Family Medicine Training,[2] 1996-1997		Total	**$5.3 million**
		Per Residency Slot	**$ 25,000**

[1] Denominator number is state population from 2000 U.S. Census.
[2] Dollar amounts refer largely to funding family medicine training programs. However, these funds that flow directly to teaching hospitals are not necessarily earmarked by the state for graduate medical education.

Sources: AAFP, AAFP State Legislation, Kahn et al., Pugno et al. and Schmittling et al. "Entry of U.S. Medical School Graduates".

New York has only half as many graduates who were first year residents in family medicine as the U.S. as a whole.

Table II-d.

NURSING EDUCATION				
# of Nursing Schools	**101**	Public Schools		**56**
		Private Schools		**45**
# of Nursing Students[1] 1998-2000	**30,307**	# Associate Degree, 1998-1999		**15,394**
		# Baccalaureate Degree	1998-1999	**10,985**
			1999-2000	**9,923**
		# Masters Degree	1998-1999	**3,713**
			1999-2000	**3,441**
		# Doctoral Degree	1998-1999	**215**
			1999-2000	**224**
	# Per 100,000 population[2]			**159.7**
# of Nursing School Graduates[1] 1999-2000	**8,462**	# Associate Degree, 1999		**4,362**
		# Baccalaureate Degree	1999	**2,965**
			2000	**2,638**
		# Masters Degree	1999	**1,103**
			2000	**1,066**
		# Doctoral Degree	1999	**32**
			2000	**21**
	# Per 100,000 population[2]			**44.6**
State Appropriations to Nursing Schools *(Baccalaureate, Masters and Doctoral)*, 1998-1999		Per Student: **$ 5,178** (2 schools reporting)		

[1] Annual figure for Associate, Baccalaureate, Masters and Doctoral students/graduates for most recent years available.
[2] Denominator number is the state population from the 2000 U.S. Census.

Sources: NLN, AACN, State higher education coordinating boards.

New York nursing school enrollments and graduations declined between 1999 and 2000.

Table II-e.

PHARMACY EDUCATION			
# of Pharmacy Schools	**4**	Public Schools	**1**
		Private Schools	**3**
# of Pharmacy Students, 2000-2001	**3,065**	# Baccalaureate Degree	**1003**
		# Doctoral Degree *(PharmD)*	**2062**
	# Per 100,000 population*		**16.2**
# of Pharmacy Graduates, 2000	**589**	# Baccalaureate Degree	**589**
		# Doctoral Degree *(PharmD)*	**0**
	# Per 100,000 population*		**3.1**

* Denominator number is state population from 2000 U.S. Census.

Source: AACP.

Table II-f.

PHYSICIAN ASSISTANT EDUCATION		
# of Physician Assistant Training Programs, 2000-2001		**19**
# of Physician Assistant Program Students, 2000-2001		**1,013**
# Physician Assistant Program Students per 100,000 Population[1]		**5.3**
# of Physician Assistant Program Graduates, 2001		**399**
# Physician Assistant Program Graduates per 100,000 Population[1]		**2.1**
State Appropriations for Physician Assistant Training Programs, 2000-2001[2]	Total	**0**
	Per Student	**0**
	As % of Total Program Revenue	**0**

[1] Denominator number is state population from 2000 U.S. Census.
[2] In general, state appropriations are not directly earmarked for these programs, but rather to their sponsoring institutions.

Sources: APAP, APAP Annual Report.

Table II-g.

DENTAL EDUCATION			
# of Dental Schools	**4**	Public Schools	**2**
		Private Schools	**2**
# of Dental Students, 2000-2001	**2,063**		
# Dental Students per 100,000 Population*	**10.9**		
# of Dental Graduates, 2000	**488**		
# Dental Graduates per 100,000 Population*	**2.6**		
State Appropriations to Dental Schools, 1998-1999	Per Student: **$ 16,187**		
	As % of Total Revenue: **23.9** (31.6 U.S.)		

* Denominator number is state population from 2000 U.S. Census.

Source: ADA.

Table II-h.

DENTAL HYGIENE EDUCATION			
# of Dental Hygiene Training Programs	**10**	Public Schools	**10**
		Private Schools	**0**
# of Dental Hygiene Program Students, 1997-1998	**867**		
# Dental Hygiene Program Students per 100,000 Population*	**4.6**		
# of Dental Hygiene Program Graduates, 1998	**346**		
# Dental Hygiene Program Graduates per 100,000 Population*	**1.8**		

* Denominator number is state population from 2000 U.S. Census.

Sources: ADHA, AMA Health Professions.

III. PHYSICIAN PRACTICE LOCATION

The following tables examine in-state physician practice location from two different vantage points: (1) of all physicians who were trained (went to medical school or received their most recent GME training) in the state between 1975 and 1995, and (2) of all physicians who are now practicing in the state, regardless of where they were trained. Complied from the American Medical Association's 1999 Physician Masterfile by Quality Resource Systems, Inc., the data importantly illustrates to what extent physician graduates practice in many of the state's small towns, using the rural-urban continuum developed by the U.S. Department of Agriculture.

PRACTICE LOCATION (URBAN/ RURAL) OF PHYSICIANS WHO RECEIVED THEIR ALLOPATHIC MEDICAL SCHOOL TRAINING IN NEW YORK BETWEEN 1975 AND 1995.

Table III-a.

NEW YORK		
Number of physicians who were trained in NY and who are now practicing in NY **as a percentage of all physicians practicing in NY**.		**34.47**
Number of physicians who were trained in NY and are practicing in NY, **by practice location** (metro code[1]), **as a percentage of all physicians practicing in NY**.	#00	33.92
	#01	46.85
	#02	38.95
	#03	35.32
	#04	33.42
	#05	26.28
	#06	32.64
	#07	28.00
	#08	42.11
	#09	0.00
Number of physicians who were trained in NY and who are now practicing in NY **as a percentage of all physicians who were trained in NY**.		**40.37**
Number of physicians who were trained in NY and are practicing in NY, **by practice location** (metro code[1]), **as a percentage of all physicians trained in NY**.	#00	47.00
	#01	28.73
	#02	25.57
	#03	11.18
	#04	24.24
	#05	28.45
	#06	28.38
	#07	10.00
	#08	29.63
	#09	0.00

[1] 1995 Rural/Urban Continuum Codes for Metro and Nonmetro Counties. Margaret A. Butler and Calvin L. Beale. Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture.

Codes # 00-03 indicate metropolitan counties:
00: Central counties of metro areas of 1 million or more
01: Fringe counties of metro areas of 1 million or more
02: Counties with metro areas of 250,000 - 1 million
03: Counties in metro areas of less than 250,000
NA: Not Applicable; no counties in the state are in the R/U Continuum Code

Codes # 04-09 indicate non-metropolitan counties:
04: Urban population of 20,000 or more, adjacent to metro area
05: Urban population of 20,000 or more, not adjacent to metro area
06: Urban population of 2,500-19,999, adjacent to metro area
07: Urban population of 2,500-19,999, not adjacent to metro area
08: Completely rural (no place w population > 2,500), adjacent to metro area
09: Completely rural (no place w population > 2,500), not adjacent to metro area

PRACTICE LOCATION (URBAN/ RURAL) OF PHYSICIANS WHO RECEIVED THEIR MOST RECENT GME TRAINING IN NEW YORK BETWEEN 1978 AND 1998.

Table III-b.

NEW YORK		
Number of physicians who received their most recent GME training in NY and who are now practicing in NY **as a percentage of all physicians practicing in NY**.		**76.80**
Number of physicians who received their most recent GME training in NY and are practicing in NY, **by practice location** (metro code[1]), **as a percentage of all physicians practicing in NY**.	#00	80.52
	#01	62.43
	#02	61.08
	#03	44.60
	#04	55.88
	#05	35.80
	#06	59.02
	#07	45.83
	#08	42.11
	#09	0.00
Number of physicians who received their most recent GME training in NY and who are now practicing in NY **as a percentage of all physicians who were trained in NY**.		**52.94**
Number of physicians who received their most recent GME training in NY and are practicing in NY, **by practice location** (metro code[1]), **as a percentage of all physicians trained in NY**.	#00	63.34
	#01	28.95
	#02	29.10
	#03	9.80
	#04	25.89
	#05	25.80
	#06	23.45
	#07	4.42
	#08	9.20
	#09	0.00

[1] 1995 Rural/Urban Continuum Codes for Metro and Nonmetro Counties. Margaret A. Butler and Calvin L. Beale. Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture.

Codes # 00-03 indicate metropolitan counties:
00: Central counties of metro areas of 1 million or more
01: Fringe counties of metro areas of 1 million or more
02: Counties with metro areas of 250,000 - 1 million
03: Counties in metro areas of less than 250,000
Codes # 04-09 indicate non-metropolitan counties:
04: Urban population of 20,000 or more, adjacent to metro area
05: Urban population of 20,000 or more, not adjacent to metro area
06: Urban population of 2,500-19,999, adjacent to metro area
07: Urban population of 2,500-19,999, not adjacent to metro area
08: Completely rural (no place w population > 2,500), adjacent to metro area
09: Completely rural (no place w population > 2,500), not adjacent to metro area
NA: Not Applicable; no counties in the state are in the R/U Continuum Code.

IV. LICENSURE AND REGULATION OF PRACTICE

States are responsible for regulating the practice of health professions by licensing each provider, determining the scope of practice of each provider type and developing practice guidelines for each profession. The tables below illustrate the licensure requirements for each of the health professions covered in this study as well as additional information on recent expansions in scope of practice or other novel regulatory measures taken by the state.

Table IV-a.

PHYSICIANS	
LICENSURE REQUIREMENTS	Graduation from registered or accredited medical program. One year of postgraduate hospital training in an accredited residency program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada. Passed examinations.
LICENSURE REQUIREMENTS: *INTERSTATE TELE-CONSULTATION*	**Full License** (through statute)
STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE	**Yes.**

Sources: State licensing board, HPTS.

Table IV-b.

PHYSICIAN ASSISTANTS	
LICENSURE REQUIREMENTS	Graduation from approved PA program and passage of National Commission on Certification of Physician Assistants (NCCPA) examination.
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	*PRESCRIPTIVE AUTHORITY* **Yes**. PA may prescribe Schedule III-V and non-controlled medications. PA must register with the Drug Enforcement Agency (DEA). *PHYSICIAN SUPERVISION* Physician not required to be physically present at time and place where PA performs services.

Source: State licensing board.

Table IV-c.

NURSES	
LICENSURE REQUIREMENTS	**Registered Nurses (RNs)** Hold a two-year degree or diploma from a accredited program in general professional nursing. Complete coursework or training in the identification and reporting of child abuse. Complete approved coursework or training appropriate to the professional's practice in infection control and barrier precautions. Pass the National Council Licensing Examination (NCLEX). **Advanced Practice Nurses (APNs)** Be licensed as a registered professional nurse in the state, have satisfactorily completed educational preparation for provision of these services in a program registered by the department or in a program determined by the department to be the equivalent or submit evidence of current certification by a national certifying body, recognized by the department **Licensed Practical Nurses (LPNs)** Graduated from at least a nine-month long program in practical nursing or completed at least three semesters (or four quarters) of an approved U.S. program in professional nursing at the associate, diploma, or baccalaureate degree level, or graduated from an approved program in general professional nursing. Must complete approved coursework or training appropriate to the professional's practice. Pass the NCLEX examination.
LICENSURE REQUIREMENTS: *FOREIGN-TRAINED NURSES*	Foreign-educated applicants seeking a limited permit as a registered professional nurse must also have their credentials verified by an independent credentials verification organization **and** document successful completion of the Commission on Graduates of Foreign Nursing Schools (CGFNS) certification program (the CGFNS examination and the Test of English as a Foreign Language), or have a score of not less than 400 on the Canadian Nurses Association Test (CNATS).
LICENSURE REQUIREMENTS: *INTERSTATE TELE-CONSULTATION*	***Full License.***
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	*PRESCRIPTIVE AUTHORITY* NP, CNM can prescribe schedules II-V with collaborative agreement. *PHYSICIAN SUPERVISION* Advanced practice nurses can practice under protocol developed with a collaborating physician.
RECENT STATE REQUIREMENTS TO IMPROVE WORKING CONDITIONS IN CERTAIN INSTITUTIONS	None
STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE	**Yes**, available on web.

Sources: State licensing board, AANA, ACNM, Pearson "Annual Legislative Update", HPTS.

Table IV-d.

DENTISTS	
LICENSURE REQUIREMENTS	Be of good moral character; be at least 21 years of age; meet education and examination requirements.
LICENSURE REQUIREMENTS: *INTERSTATE TELE-CONSULTATION*	**Full License.**

Source: State licensing board.

Table IV-e.

PHARMACISTS	
LICENSURE REQUIREMENTS	Complete a program of pharmacy that is registered by the Department or accredited by the American Council on Pharmaceutical Education (ACPE); North American Pharmacist Licensure Examination (NAPLEX) and experience requirements.
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	No.
STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE	**No.**

Source: State licensing board.

Table IV-f.

DENTAL HYGIENISTS	
LICENSURE REQUIREMENTS	Be of good moral character; meet education and examination requirements; be at least 17 years of age for dental hygiene licensure by examination.
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	*PRESCRIPTIVE AUTHORITY* No. Legislation passed to administer nitrous oxide, not signed by governor. *DENTIST SUPERVISION* Hygienists must be supervised by a dentist.

Source: State licensing board, ADHA.

Glossary of Acronyms

CNM: Certified nurse midwife.
CRNA: Certified registered nurse anesthetist.
NP: Nurse practitioner.

V. IMPROVING THE PRACTICE ENVIRONMENT

States have the challenge of not only helping to create an adequate supply of health professionals in the state, but also ensuring that those health professionals are distributed evenly throughout the state. Various programs and incentives are used by states to encourage providers to practice in rural and other underserved areas. The tables in this section describe New York's programs as well as the perceived effectiveness of these programs.

RECRUITMENT/ RETENTION INITIATIVES

Table V-a.

INITIATIVE	In Use	Perceived or Known Impact (1= high, 5= low)	Health Professions Affected					
			Physicians	Nurses	Pharmacists	Dentists	Dental Hygienists	Physician Assistants
FOCUSED ADMISSIONS / RECRUITMENT OF STUDENTS FROM RURAL OR UNDERSERVED AREAS	**Yes**	**1**	**X**					
SUPPORT FOR HEALTH PROFESSIONS EDUCATION (stipends, preceptorships) IN UNDERSERVED AREAS	**Yes**	**1**	**X**					
RECRUITMENT / PLACEMENT PROGRAMS FOR HEALTH PROFESSIONALS	**No**							
PRACTICE DEVELOPMENT SUBSIDIES (i.e., start-up grants)	**No**							
MALPRACTICE PREMIUM SUBSIDIES	**No**							
TAX CREDITS FOR RURAL / UNDERSERVED AREA PRACTICE	**No**							
PROVIDING SUBSTITUTE PHYSICIANS (*locum tenens* support)	**No**							
MALPRACTICE IMMUNITY FOR PROVIDING VOLUNTARY OR FREE CARE	**No**							
PAYMENT BONUSES / OTHER INCENTIVES BY MEDICAID OR OTHER INSURANCE CARRIERS	**No**							
MEDICAID REIMBURSEMENT OF TELEMEDICINE	**No**							

***Source*: State health officials.**

New York uses focused admissions and stipends for students in rural or underserved areas as recruitment strategies for physicians.

LOAN REPAYMENT/ SCHOLARSHIP PROGRAMS *

Table V-b.

Program Type	Number of Programs	Number of Annual Participants	Average Retention Rate	Eligible Health Professions					
				Physicians	Nurses	Pharmacists	Dentists	Dental Hygienists	Physician Assistants
LOAN REPAYMENT	1	80	Not Available	X					
SCHOLARSHIP	0	0	N/A*						

*** Includes only state-funded programs which require a service obligation in an underserved area. (NHSC state loan repayment programs are included since the state provides funding.)**
N/A* = Data is not applicable

Source: State health officials.

WORKFORCE PLANNING ACTIVITIES*

Table V-c.

ACTIVITY	In Use	Health Professions Affected					
		Physicians	Nurses	Pharmacists	Dentists	Dental Hygienists	Physician Assistants
COLLECTION / ANALYSIS OF PROFESSIONS SUPPLY DATA: FROM *PRIMARY* SOURCES (e.g., licensure renewal process; other survey research)	Yes	X	X	X	X	X	X
FROM *SECONDARY* SOURCES (e.g., state-based professional trade associations)	Yes	X	X	X	X	X	X
PRODUCTION OF RECENT STUDIES OR REPORTS THAT DOCUMENT / EVALUATE THE SUPPLY, DISTRIBUTION, EDUCATION OR REGULATION OF HEALTH PROFESSIONS	Yes	X	X	X	X	X	X
RECENT REGULATORY ACTIONS INTENDED TO REQUIRE OR ENCOURAGE COORDINATION OF POLICIES AND DATA COLLECTION AMONG HEALTH PROFESSIONS GROUPS OR LICENSING BOARDS	No						

* One state health official supplied these responses. Therefore, data may be limited and may not accurately reflect all current workforce-planning activities in the state.

New York collects supply data and produces studies and evaluations for all the major health professions.

VI. EXEMPLARY WORKFORCE LEGISLATION, PROGRAMS AND STUDIES

The following abstracts describe several of New York's recent endeavors to understand and describe the status of the state's current health care workforce.

Legislation and Programs

All-Payor (Private Payor) Funding

New York is one of two states that require all-payors to contribute to graduate medical education. The state created the "Professional Education Pool" through which funding for graduate medical education is collected and distributed.[1] The amount of money in the Professional Education Pool is quite substantial, $670 million in 2001, but will be reduced annually until 2003 when the Legislature will re-examine the pool due to a sunset clause in the legislation. New York requires all payors to contribute to the fund, including Blue Cross and Blue Shield, commercial insurers, health maintenance organizations (non-Medicaid and non-Medicare), businesses, self-insured funds, and third party administrators.

Payors can make payments two ways. First, the payor can voluntarily contribute directly to the fund based on an assessment on per covered life of the individuals or families covered by the plan. If the payor does not make the contribution directly to the fund, the payor will be assessed a surcharge on each payment for inpatient hospital services. The surcharge is based on a regionally determined equivalent assessment of inpatient costs plus a 24 percent differential. The hospital then sends the surcharge to the commissioner. The Professional Education Pool monies are distributed to teaching hospitals on a monthly basis according to the hospital's adjusted share of a region's total GME spending. In addition, $54 million is distributed to teaching hospitals that meet specific training goals, such as increasing the proportion of primary care residencies and increasing the number of residents in underserved areas and ambulatory care settings. New York's statute also includes monetary penalty provisions if the private payor failed to contribute to the fund.

Graduate Medical Education Reform Incentive Pool

The Graduate Medical Education Incentive Pool carves out ten percent of the funds from the Professional Education Pool to encourage hospitals to support GME reform initiatives. Rather than relying on statewide solutions for GME reform, the program allows variation in different geographic regions. The goals of the GME Incentive Pool are to 1) reduce the number of residency positions and programs; 2) increase training in primary care; 3) maintain the quality of the education program; 4) increase minority participation; 5) increase training in ambulatory settings for primary care physicians; 6) retain primary care graduates to remain and practice in New York state; and 7) to increase training in rural, urban, and underserved communities.

http://www.health.state.ny.us/nysdoh/gme/main.htm

[1] NY CLS Pub Health § 2807-m (1999)

Studies

The Health Care Workforce in New York City, 2001: Trends in the Supply and Demand For Health Workers in New York City

The Center for Health Workforce Studies, School of Public Health, University of Albany, September 2001

The third annual report on health workforce trends in New York City examines the health workforce by setting, sector, and occupation using data sources, interviews and various studies. Specifically, the report looks at the rate of growth of the health care workforce, hospital employment trends and certificate of need approvals (CON) the supply by occupation, trends in nursing education, and the demand for health care workers in different settings.

The paper noted that the health industry is experiencing significant worker shortages and nurses and pharmacists are among the most difficult to recruit occupations at public hospitals. The report suggests that some of the factors contributing to the shortage of registered nurses (RNs) are the decline of RN graduates in the city, the aging of the existing workforce, and the growing demand for nurses in other settings.

The Supply and Distribution of Primary Care Nurse Practitioners in New York State

The Center for Health Workforce Studies, School of Public Health, University of Albany, August 2001

This report looks at the supply and distribution of primary care nurse practitioners (NPs) in New York State. The study used survey responses from 6039 actively practicing patient care NPs to break down supply and distribution by specialty and location.

Meeting Future Nursing Needs of New Yorkers: A Study of Registered Nursing in New York State

Center for Health Workforce Studies-University of Albany, May 2000

This study of the registered nurse (RN) workforce in the state found the number of nursing graduates has been declining steadily and there is likely to a be a growing shortage of RNs in the state in the next few years. The Center suggests that 1) RN graduations from nursing schools be increased moderately; 2) continuing education programs for RNs are critical given the changes in medical intervention; and 3) clinical training or new registered nurses should be expanded.

Trends in Nursing Education in New York State, 1991-2002

Center for Health Workforce Studies-University of Albany, April 2001

The Center for Health Workforce Studies surveyed registered nursing education programs in the state. It found that RN production in the state had declined steadily from 1996 to 2000, and that the number of graduates is expected to remain the same in 2001. The survey found that associate degree nurses had decreased by nearly 32% while the production of bachelor degree nurses had decreased by 11% in a four-year period.

Trends in Registered Nursing Graduations in New York, 1996-2001

Center for Health Workforce Studies-University of Albany, April 2002

The Center surveyed registered nurse education programs in 2001. According to the report, the number of RNs graduating in New York State declined for the fifth straight year. Every region in the state had fewer RN graduations in 2001 than in 1996. The study further notes that the number of RN graduates projected for 2003 is unlikely to be sufficient to meet the demand for registered nurses despite a projected increase in the number of graduates.

Residency Training Outcomes by Specialty in 2000 for New York State
A Summary of Response to the 2000 NYS Resident Exit Survey
Center for Health Workforce Studies-University of Albany, 2000
This report summarizes the key findings from the Center's annual survey of all physicians completing a residency or fellowship training program in the state. The study found that the overall job market for new physicians in the state was good. Only 5% of respondents who had actively searched had not received any job offers at the time of the survey. The study also found that demand for primary care physicians is lower than demand for non primary care physicians and that there are significant differences in the job market for different specialties. Most of the respondents were remaining in New York to begin practice.

Profile of New York State Physicians
Center for Health Workforce Studies-University of Albany, April 2001
This report provides data on primary care physicians, obstetricians/gynecologists, and psychiatrists in the state. It includes data on the absolute number of physicians and full-time equivalents in each specialty from 1995 to 1999, the number of physicians per 100,000 population in each specialty, and age and race/ethnicity profiles of physicians in each geographic area.

Resolving New York's Nursing Shortage: Recommendations for Addressing the Nursing Shortage in New York State
A Report from the Assembly Minority Nursing Shortage Task Force, August 2001
The task force was assembled in March of 2001 and charged with collecting information on the shortage of practicing nurses, hearing testimony from concerned parties adversely effected by the shortage, and developing a set of recommendation to address the shortage. The Task Force found that the nursing shortage is having an effect on the quality and availability of care in New York. Participants noted that Hospitals have cancelled scheduled surgeries and diverted ambulances, nursing homes have reported closing beds, and home care agencies are unable to accept referrals due to the current shortage. Nurses complained of poor working conditions, being forced to work mandatory overtimes, lack of communication between nurses and administrators, burdensome paperwork, and low salaries. The task force recommended 1) making scholarships and stipends available to nursing students; 2) bolstering nursing education programs; 3) supporting a coordinated campaign to interest young people in nursing and health careers; 4) collecting data on the breadth and depth of the shortage; and 5) implementing measures designed to improve working conditions and retain nurses.

A Report on the Supply and Demand for Registered Nurses in New York State
New York State Nurses Association, 2000
The report found that the current demand for registered nurses in the state is greater than the supply, and that the supply of RNs is likely to decrease over the next few years due to the recent decreases in enrollments in nursing programs. It also noted that there is a lack of regularly collected data on RNs and their employment patterns. The report concluded that more data was needed to assess the workforce needs and that steps should be taken to increase the overall supply of RNs.

Protecting the Public: The Future of Nursing in New York State
New York State Board of Regents: Blue Ribbon Task Force on the Future of Nursing, September 2001
This report describes the nursing shortage in New York and defines the relationship between nursing education an the supply of nurses. The task force sites the aging workforce, under-representation of minorities, more career opportunities for women, inaccurate projections of need, the workplace environment, and the aging population as factors affecting the current shortage. The task force recommended using initiatives to retain the current nursing workforce, undertaking recruitment efforts to expand the workforce, providing additional academic and financial support systems to increase the number of nursing school graduates, and developing reliable central source of data on the nursing workforce to address the current nursing shortage.

HRSA State Health Workforce Profile

Bureau of Health Professions, December 2000

The State Health Workforce Profiles provide current data on the supply, demand, distribution, education and use of health care professionals in each state. Each state profile has an overview of the health status of state residents and health services within the state. In addition the profiles have breakdowns of health care employment by place of work and profession.

http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm

VII. POLICY ANALYSIS

Organizations with Significant Involvement in Health Workforce Analysis/Development

- **Healthcare Association of New York State**
- **New York State Nurses Association**
- **New York State Department of Health**
- **Legislature**
- **Center for Health Workforce Studies-SUNY, Albany**
- **New York State Board of Regents**

Evidence of Collaboration: <u>Minimum to Moderate</u> (largely associated with workforce recruitment and retraining, and workforce data assimilation)

Although New York is largely metropolitan, the upper portion of the state has a significant rural population. The state's minority and ethnic population accounts for over a third of New York's total population.

By various indicators, New York residents enjoy higher access to health care services than most states. A larger proportion of residents visit a physician and dentist, and the proportion of the population living in primary care and dental health professional shortage areas (HPSAs) is below the national average. Also, the overall ratio of the number of most health professionals to the population is much higher in New York than the U.S. as a whole. There is also a smaller percent of the population without health insurance than the U.S. as a whole, and the percent is shrinking.

New York state government has a long history of addressing state health workforce issues in the context of larger health system changes and reforms. Public third party payment rates to the state's hospital and health care system historically have been centrally regulated by the state. In that context, no significant change in Medicaid payment rates to physicians and dentists appear to have occurred in the past decade. Since 1997, however, payment rates have been deregulated in favor of market-based negotiation.

The state also has numerous grant and loan programs intended to improve the supply of health professionals in primary care and long-term care disciplines and in rural and indigent underserved communities. State officials rank their initiatives to recruit medical students from rural or underserved areas and state support for health professions education in underserved communities as having a major impact on recruiting and retaining health professionals to needy areas of the state.

New York devotes significant attention to better understanding its health workforce needs through collection and analysis of data on the state's health professions in training and practice. The Center for Health Workforce Studies at the State University of New York in Albany routinely provides state officials and others respected reports and analyses of physician and nurse supply in the state. The state hospital and nursing associations, as well as the state's major health professional licensing boards, also regularly collect workforce data on members or licensees that is made available to state policymakers.

A recent economic recession and growing shortages of nurses and other health professionals in the state have focused attention on efforts to establish a major new state-funded health workforce retraining initiative. State-supported health worker retraining was originally established in the early 1990s. The latest initiative is supported by a coalition of hospitals, nursing homes, nurse executives, home care agencies and adult care facilities. Health care workers in these settings are heavily unionized, and such unions have significant influence on state policymakers. In 2001, the coalition called for new state funds to support 1) improvements in health care staff wages and benefits, 2) expansion and renewal of

scholarships, grants and public education programs that offer financial incentives to enter or re-enter the health care field, and 3) promotion of health care as an attractive career.

In early 2002, the governor's proposed $3 billion health care plan—approved by the Legislature and endorsed by the state's powerful hospital union—increases salaries for health care employees and restores some reductions in Medicaid services that were previously proposed. Pharmacists who provide drugs to poor seniors will see a loss of $25 million in Medicaid funds--$175 million less than originally proposed by the governor. The plan also provides $80 million in grants to hospitals, nursing homes and other qualified agencies for recruitment, retention and training of health care workers, and awards $28 million for various primary care initiatives and projects. In addition, the budget replenishes a fund to help cover large malpractice claims against physicians. Physicians in New York face sharp increases in 2002 in their malpractice insurance premiums. Nationwide, annual malpractice insurance rates have increased an average of 30 percent. In his 2002 state-of-the-state address, the governor also announced plans to have legislation introduced that would support increased staffing in various health care facilities.

Physicians

New York has the second highest proportion of practicing physicians per 100,000 population of any state in the country. However, despite such overall abundance of physicians statewide, there are many areas of the state—particularly rural in nature—where supply of specialty and primary care physicians is low and access to care is limited. In 1999, the Legislature authorized the state Board of Regents to extend a waiver allowing physicians with alien citizenship who are completing a service obligation under an approved VISA waiver program to work in medically underserved areas of the state.

New York is a major producer of physicians. The state has 13 medical schools and over 100 teaching hospitals that graduate over 1,900 physicians a year and house over 10 percent of all the medical students in the country. New York also has more medical residents per 100,000 population than any other state. In 1999-2000, the state had over 14,700 residents training in more than 1,100 programs.

With this level of production, the state fares well in retaining a significant portion of its graduates. About three-fourths of currently practicing physicians completed their most recent GME in the state. In 2000, just over half of graduating residents report remaining in state to practice. Of those, 17 percent report entering practice in a HPSA and 7 percent in some rural area of the state.

State support for medical schools is relatively small and declining. State appropriations to the four public schools dropped significantly in the 1980s and 1990s. Despite a decline in state support for family medicine residency programs, New York has been a leader in encouraging graduate training in primary care. The state's Council on Graduate Medical Education, located in the Department of Health, first called for training of primary care residents in ambulatory settings in the mid 1980s. In 1992, the Legislature, based on the Council's recommendation, passed a law to weight primary care more heavily in non-Medicare, state indirect medical education payments to teaching hospitals.

In 1996, another law instituted a new system for financing graduate medical education that includes an assessment on insurers and purchasers of health care and distributes payments by region. The state Medicaid agency now provides over $800 million annually in GME payments, which continue to go directly to teaching programs under managed care. The 1996 law also called for the competitive distribution of up to $54 million annually to approved graduate training consortia and hospitals based on state workforce goals including increasing the proportion of residents trained in primary care. Presently, in its fourth year of operation, the physician training incentive pool is funded at about $25 million annually. Funds are distributed to encourage an increase in the number of underrepresented minorities and training in ambulatory settings.

A 2000 state law required the Department of Health to establish a system for collecting various information on the state's 72,000 licensed physicians that would be available for public review. In early 2002, the state launched a website containing information on physician criminal convictions, disciplinary actions, educational history, location of primary practice, hospital privileges and malpractice judgments. The same information is available by calling a toll-free telephone number.

Nursing

With over 300,000 licensed nurses, New York has the second largest population of nurses of any state in the nation. Despite this abundance of nurses, there are indications of a growing nursing shortage. Recent surveys find that three-quarters of the state's hospitals report nursing shortages, particularly outside of New York City. Vacancies for registered nurses reportedly take an average of three months to fill. There are also reports that up to 19 percent of licensed nurses in the state are employed outside of nursing. On average, the state's more than 100 nursing schools have seen a continuous drop in both enrollment and graduations over the last five to six years. Several schools report inadequate training capacity as the major problem, particularly the lack of qualified faculty. Reports issued in the past two years by the Legislature, state hospital and nursing associations, state Board of Regents, and others provide documentation as well as recommendations to address the problem. However, there remains concern about the lack of a reliable central source of data and analysis on nursing supply and demand in the state. The nursing association's focus for addressing the problem is on retention and finding ways to improve working conditions for nurses.

The state has been slow to provide support to address the shortage problem. Legislation in 2001 calling for a limitation on mandatory overtime for nurses, creation of a minimum nurse staffing formula, whistleblower protection, creation of a statewide nurse staffing center, and establishment of a state nursing scholarship program await lawmaker action in 2002 (as of April 2002).

Dentists and Pharmacists

New York has focused much less attention on the dental and pharmacy workforce.

As elsewhere, the shortage of dentists who serve Medicaid recipients is a problem in New York. Concerns by dentists over low Medicaid payment rates resulted in a 2000 suit of the state by the state dental association. As a result of the suit, dentists won the right to receive incremental Medicaid rate increases.

The state has relatively liberal licensing requirements for dentists that allow larger numbers of foreign trained and out-of-state dentists to practice in New York. However, shortages of dentists are becoming more acute in rural areas of the state. Fewer younger dentists are choosing buy the rural practices of a growing number of older dentists facing retirement. A 2001 rural health summit in New York called on the state to develop more incentives to get dentists to locate to rural communities and give dental hygienists in rural areas the authority to bill Medicaid directly. The state does not currently have a dentist loan repayment program, although proposed 2002 legislation would establish such a program. There are reports of regional shortages of hygienists despite the fact that New York's 10 oral hygiene schools are spread across the state.

Reports of a shortage of pharmacists, particularly in smaller rural hospitals, are increasing. Offers of higher compensation and better hours from a growing presence of chain drug stores is luring pharmacists from hospitals. Consequently, many hospitals reportedly are now having to contract more for pharmacist services.

New York is one of two states receiving a federal demonstration grant in late 2001 to help organizations that participate in the 340B drug discount program to find creative ways to reduce

administrative costs and improve access to prescription drugs for safety net patient. The 340B program requires drug manufacturers to sell drugs to specified safety-net providers at a discount rate. A group of 11 community health centers in Ticonderoga uses grant funds to contract with multiple pharmacies to make medications and pharmacy services more available to indigent patients served by the health centers.

DATA SOURCES

Workforce Supply and Demand

American Association of Retired Persons, Public Policy Institute (AARP). Reforming the Health Care System: State Profiles 2001. (Washington, DC: 2002).

Bureau of Primary Health Care, Division of Shortage Designation (BPHC-DSD). Selected Statistics on Health Professional Shortage Areas (Bethesda, MD: December 2001).

Bureau of Primary Health Care, National Health Service Corps (BPHC-NHSC). National Health Service Corps Field Strength: Fiscal Year 2001 (Bethesda, MD: March 2002).

Centers for Disease Control and Prevention (CDC). Morbidity and Mortality Weekly Report: State Specific Prevalence of Selected Health Behaviors, by Race and Ethnicity—Behavioral Risk Factor Surveillance System, 1997. (Atlanta, GA: March 24, 2000) Vol. 49, No. SS-2.

Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Information and Analysis (HRSA-BHPr). State Health Workforce Profiles (Bethesda, MD: December 2000).

Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing (HRSA-BHPr). The Registered Nurse Population, March 2000: Findings from the National Sample Survey of Registered Nurses (Rockville, MD: February 2002).

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured (KFF). Health Insurance Coverage in America: 1999 Data Update (Palo Alto, CA: January 2001).

National Conference of State Legislatures, Health Policy Tracking Service (HPTS).

Personal conversations with HCFA regional office officials.

S. Norton and S. Zuckerman. "Trends in Medicaid Physician Fees" Health Affairs. 19(4), July/August 2000.

State Medicaid programs (data from NCSL survey).

United States Department of Commerce, U.S. Census Bureau.

United States General Accounting Office (GAO). Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations. (Washington, DC: April 2000) GAO/HEHS-00-72.

Health Professions Education

American Academy of Family Physicians (AAFP)

American Academy of Family Physicians. State Legislation and Funding for Family Practice Programs. (Washington, DC).

American Association of Colleges of Nursing (AACN)

American Association of Colleges of Osteopathic Medicine (AACOM). Annual Statistical Report. (Chevy Chase, MD).

American Association of Colleges of Pharmacy (AACP). Profile of Pharmacy Students. (Alexandria, VA).

American Dental Association (ADA)

American Dental Association. 1997-1998 Survey of Predoctoral Dental Educational Institutions. (Washington, DC).

American Dental Hygienist Association (ADHA)

American Medical Association (AMA). Health Professions Career and Education Directory.

American Medical Association. State-level Data for Accredited Graduate Medical Education Programs in the U.S.: 2000-2001. (Washington, DC: 2002)

Association of American Medical Colleges (AAMC)

Association of American Medical Colleges. Institutional Goals Ranking Report. (AAMC website).

Association of Physician Assistant Programs (APAP).

Association of Physician Assistant Programs. Seventeenth Annual Report on Physician Assistant Educational Programs in the United States, 2000-2001. (Loretto, PA: 2001).

Barzansky B. et al., "Educational Programs in U.S. Medical Schools, 2000-2001" JAMA. 286(9), September 5, 2001.

Henderson, T., Funding of Graduate Medical Education by State Medicaid Programs, prepared for the Association of American Medical Colleges, April 1999.

Kahn N. et al., "Entry of U.S. Medical School Graduates into Family Practice Residencies: 1997-1998 and 3-year Summary" Family Medicine. 30(8), September 1998.

Kahn N. et al., "Entry of U.S. Medical School Graduates into Family Practice Residencies: 1996-1997 and 3-year Summary" Family Medicine. 29(8), September 1997.

Kahn N. et al., "Entry of U.S. Medical School Graduates into Family Practice Residencies: 1995-1996 and 3-year Summary" Family Medicine. 28(8), September 1996.

National League for Nursing (NLN)

Oliver T. et al., State Variations in Medicare Payments for Graduate Medical Education in California and Other States, prepared for the California HealthCare Foundation. (Data from the Health Care Financing
Administration, compiled by the Congressional Research Service.)

Pugno P. et al.. "Entry of U.S. Medical School Graduates into Family Practice Residencies: 1999-2000 and 3-year Summary" Family Medicine. 32(8), September 2000.

Pugno P. et al.. "Entry of U.S. Medical School Graduates into Family Practice Residencies: 2000-2001 and 3-year Summary" Family Medicine. 33(8), September 2001.

Schmittling G. et al. "Entry of U.S. Medical School Graduates into Family Practice Residencies: 1998-1999 and 3-year Summary" Family Medicine. 31(8), September 1999.

State higher education coordinating board/university board of trustees (data from NCSL survey).

Physician Practice Location

1999 American Medical Association Physician Masterfile. Computations were performed by Quality Resource Systems, Inc. of Fairfax, Virginia.

Licensure and Regulation of Practice

American Association of Nurse Anesthetists (AANA)

American College of Nurse Midwives (ACNM). Direct Entry Midwifery: A Summary of State Laws and Regulations. (Washington, DC: 1999).

American College of Nurse Midwives. Nurse-Midwifery Today: A Handbook of State Laws and Regulations. (Washington, DC: 1999).

American Dental Hygienist Association

National Conference of State Legislatures, Health Policy Tracking Service.

Pearson L., editor. "Annual Legislative Update: How Each State Stands on Legislative Issues Affecting
Advanced Nursing Practice" The Nurse Practitioner. 25(1), January 2001.

State licensing boards (NCSL survey).

Improving the Practice Environment

State health officials (NCSL survey).